

# MEDICAL ELIGIBILITY DETERMINATION

Page 1 of 1

## Background Information

Assessment Start Date: --  
Month Day Year

Provider-Assessor # -

Name of Person Coordinating Assessment \_\_\_\_\_ Title \_\_\_\_\_

Agency/Organization \_\_\_\_\_ Phone Number \_\_\_\_\_

### SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

|                                  |   |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
|----------------------------------|---|---|----------------------------------|----------------------------|-----------------------------------|---------------------------|----------------------------------|----------------------|-------------------------------------|-------------------------|----------------------------|--------------------------|---------------------------------------|------------------------|----------------------|-------------------|-----------------------|----------------|------------------------|-----------------------------|--------|--------------------------|---------------------------|----------------------------|-------------------------------|----------------------------|-----------------------------------|-------------------|---------------------------|-------------------------------|--|---------------------------|--|----------------------------------|--------------------------|
| 1.                               | APPLICANT NAME                                  | First: _____ (MI) _____<br>Last: _____  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 2.                               | ADDRESS   | Street _____<br>City/Town _____ Cnty _____ State _____<br>Zip _____ Phone (____) _____  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 3.                               | SOCIAL SECURITY NO.                             | <input type="text"/> - <input type="text"/> - <input type="text"/>  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 4.                               | MAINECARE NO. (if applicable)                   | <input type="text"/>  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 5.                               | MEDICARE NO.                                    | <input type="text"/>  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 6A.                              | ASSESSMENT TRIGGER                              | 1. Service Need<br>2. Reassessment due<br>3. Significant Medical Change<br>4. Financial Change <input type="checkbox"/>   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 6B.                              | PROGRAM ASSESSMENT REQUESTED (Choose only one.) | <table border="0"> <tr> <td>1. Long Term Care Advisory</td> <td>17. 30-day Community MaineCare NF</td> </tr> <tr> <td>2. Adult Day Care Program</td> <td>18. Advisory to MaineCare Update</td> </tr> <tr> <td>3. BEAS Home Maker</td> <td>19. Adv. Medicare to Private Pay NF</td> </tr> <tr> <td>4. MaineCare Day Health</td> <td>20. Continuing Stay/Review</td> </tr> <tr> <td>5. Consumer Directed PCA</td> <td>21. Extraordinary Circumstances to NF</td> </tr> <tr> <td>6. Home Based Care</td> <td>22. Katie Beckett</td> </tr> <tr> <td>7. Phys. Dis. HCB</td> <td>23. NF PDN - Level IV</td> </tr> <tr> <td>8. Elderly HCB</td> <td>24. Congregate Housing</td> </tr> <tr> <td>9. Adults w/ Disability HCB</td> <td>25. TH</td> </tr> <tr> <td>10. PDN Level I, II, III</td> <td>26. MaineCare Home Health</td> </tr> <tr> <td>11. Adult Family Care Home</td> <td>27. PDN Medication - Level VI</td> </tr> <tr> <td>12. Level V - Extended PDN</td> <td>28. PDN Puncture Only - Level VII</td> </tr> <tr> <td>13. NF Assessment</td> <td>29. Consumer Directed HCB</td> </tr> <tr> <td>14. 20-day Medicare/MaineCare</td> <td></td> </tr> <tr> <td>15. Medicare to MaineCare</td> <td></td> </tr> <tr> <td>16. 20-day copay to NF MaineCare</td> <td><input type="checkbox"/></td> </tr> </table> |                                  | 1. Long Term Care Advisory | 17. 30-day Community MaineCare NF | 2. Adult Day Care Program | 18. Advisory to MaineCare Update | 3. BEAS Home Maker   | 19. Adv. Medicare to Private Pay NF | 4. MaineCare Day Health | 20. Continuing Stay/Review | 5. Consumer Directed PCA | 21. Extraordinary Circumstances to NF | 6. Home Based Care     | 22. Katie Beckett    | 7. Phys. Dis. HCB | 23. NF PDN - Level IV | 8. Elderly HCB | 24. Congregate Housing | 9. Adults w/ Disability HCB | 25. TH | 10. PDN Level I, II, III | 26. MaineCare Home Health | 11. Adult Family Care Home | 27. PDN Medication - Level VI | 12. Level V - Extended PDN | 28. PDN Puncture Only - Level VII | 13. NF Assessment | 29. Consumer Directed HCB | 14. 20-day Medicare/MaineCare |  | 15. Medicare to MaineCare |  | 16. 20-day copay to NF MaineCare | <input type="checkbox"/> |
| 1. Long Term Care Advisory       | 17. 30-day Community MaineCare NF               |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 2. Adult Day Care Program        | 18. Advisory to MaineCare Update                |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 3. BEAS Home Maker               | 19. Adv. Medicare to Private Pay NF             |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 4. MaineCare Day Health          | 20. Continuing Stay/Review                      |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 5. Consumer Directed PCA         | 21. Extraordinary Circumstances to NF           |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 6. Home Based Care               | 22. Katie Beckett                               |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 7. Phys. Dis. HCB                | 23. NF PDN - Level IV                           |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 8. Elderly HCB                   | 24. Congregate Housing                          |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 9. Adults w/ Disability HCB      | 25. TH  |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 10. PDN Level I, II, III         | 26. MaineCare Home Health                       |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 11. Adult Family Care Home       | 27. PDN Medication - Level VI                   |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 12. Level V - Extended PDN       | 28. PDN Puncture Only - Level VII               |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 13. NF Assessment                | 29. Consumer Directed HCB                       |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 14. 20-day Medicare/MaineCare    |   |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 15. Medicare to MaineCare        |   |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 16. 20-day copay to NF MaineCare | <input type="checkbox"/>                        |   |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 7.                               | GENDER  | 1. Male 2. Female <input type="checkbox"/>  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 8.                               | RACE/ETHNICITY (Optional)                       | 1. American Indian/Alaskan<br>2. Asian/Pacific<br>3. Black<br>4. Hispanic<br>5. White<br>6. Other <input type="checkbox"/>  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 9.                               | BIRTH DATE                                      | <input type="text"/> - <input type="text"/> - <input type="text"/><br>Month Day Year  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 10A.                             | MARITAL STATUS                                  | 1. Never married<br>2. Married<br>3. Widowed<br>4. Separated<br>5. Divorced <input type="checkbox"/>  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 10B.                             | CITIZENSHIP                                     | 1. U.S. Citizen 2. Legal alien 3. Other <input type="checkbox"/>  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 11.                              | PRIMARY LANGUAGE                                | 0. English<br>1. French<br>2. Spanish<br>3. Other _____ <input type="checkbox"/>  |                                  |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| 12.                              | CURRENT INCOME SOURCE FOR APPLICANT & HOUSEHOLD | (Check all that apply.)<br><table border="0"> <tr> <td>a/b. Social Security</td> <td>App. Hshld. <input type="text"/></td> <td>g/h. SSI</td> <td>App. Hshld. <input type="text"/></td> </tr> <tr> <td>c/d. Private Pension</td> <td><input type="text"/></td> <td>i/j. Other</td> <td><input type="text"/></td> </tr> <tr> <td>e/f. VA Benefits</td> <td><input type="text"/></td> <td>k/l. Assets &gt;\$2000.00</td> <td><input type="text"/></td> </tr> </table>  |                                  | a/b. Social Security       | App. Hshld. <input type="text"/>  | g/h. SSI                  | App. Hshld. <input type="text"/> | c/d. Private Pension | <input type="text"/>                | i/j. Other              | <input type="text"/>       | e/f. VA Benefits         | <input type="text"/>                  | k/l. Assets >\$2000.00 | <input type="text"/> |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| a/b. Social Security             | App. Hshld. <input type="text"/>                | g/h. SSI  | App. Hshld. <input type="text"/> |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| c/d. Private Pension             | <input type="text"/>                            | i/j. Other  | <input type="text"/>             |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |
| e/f. VA Benefits                 | <input type="text"/>                            | k/l. Assets >\$2000.00  | <input type="text"/>             |                            |                                   |                           |                                  |                      |                                     |                         |                            |                          |                                       |                        |                      |                   |                       |                |                        |                             |        |                          |                           |                            |                               |                            |                                   |                   |                           |                               |  |                           |  |                                  |                          |

|   |  |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
|---|--|--|----------------------|---|----------------------|------------------------------|-------------------------|--------------------------|---------------------------|------------------------------|----------------------|--|----------------------|-----------------------------------|----------------------|-----------------------------|----------------------|------------------|----------------------|--------------------|----------------------|----------------|----------------------|--------------------|----------------------|--|--|
| 13.   | CURRENT OR POTENTIAL PAYMENT SOURCE (Code a response in each box.)                 | 0. Not eligible<br>1. Eligible<br>2. Eligibility pending (application filed)<br>3. Eligibility anticipated (application not yet filed)<br>4. Unknown<br><table border="0"> <tr> <td>a. Community MaineCare (Routine home health, PDN)</td> <td><input type="text"/></td> <td>g. Champus</td> <td><input type="text"/></td> </tr> <tr> <td>b. HCB - Elderly, AD</td> <td><input type="text"/></td> <td>h. VA</td> <td><input type="text"/></td> </tr> <tr> <td>c. HCB - Phys. Dis.</td> <td><input type="text"/></td> <td>i. Title XX</td> <td><input type="text"/></td> </tr> <tr> <td>d. NF MaineCare</td> <td><input type="text"/></td> <td>j. Other</td> <td><input type="text"/></td> </tr> <tr> <td>e. Medicare Part A</td> <td><input type="text"/></td> <td></td> <td></td> </tr> <tr> <td>f. Medicare Part B</td> <td><input type="text"/></td> <td></td> <td></td> </tr> </table> |                      | a. Community MaineCare (Routine home health, PDN) | <input type="text"/> | g. Champus                   | <input type="text"/>    | b. HCB - Elderly, AD     | <input type="text"/>      | h. VA                        | <input type="text"/> | c. HCB - Phys. Dis.                          | <input type="text"/> | i. Title XX                       | <input type="text"/> | d. NF MaineCare             | <input type="text"/> | j. Other         | <input type="text"/> | e. Medicare Part A | <input type="text"/> |                |                      | f. Medicare Part B | <input type="text"/> |  |  |
| a. Community MaineCare (Routine home health, PDN) | <input type="text"/>   | g. Champus   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| b. HCB - Elderly, AD                              | <input type="text"/>   | h. VA  | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| c. HCB - Phys. Dis.                               | <input type="text"/>   | i. Title XX  | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| d. NF MaineCare                                   | <input type="text"/>   | j. Other   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| e. Medicare Part A                                | <input type="text"/>   |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| f. Medicare Part B                                | <input type="text"/>   |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 14.   | LOCATION AT TIME OF ASSESSMENT & USUAL RESIDENCE                                   | <table border="0"> <tr> <td>1. Hospital</td> <td>5. Nursing Home</td> </tr> <tr> <td>2. Home/apartment</td> <td>6. Assisted Living Unit</td> </tr> <tr> <td>3. Congregate housing</td> <td>7. Adult Family Care Home</td> </tr> <tr> <td>4. Residential Care Facility</td> <td>8. Adult Foster Home</td> </tr> <tr> <td></td> <td>9. Other _____</td> </tr> </table> <table border="0"> <tr> <td>A. Location at time of assessment</td> <td><input type="text"/></td> </tr> <tr> <td>B. Usual place of residence</td> <td><input type="text"/></td> </tr> </table>   |                      | 1. Hospital                                       | 5. Nursing Home      | 2. Home/apartment            | 6. Assisted Living Unit | 3. Congregate housing    | 7. Adult Family Care Home | 4. Residential Care Facility | 8. Adult Foster Home |  | 9. Other _____       | A. Location at time of assessment | <input type="text"/> | B. Usual place of residence | <input type="text"/> |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 1. Hospital                                       | 5. Nursing Home  |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 2. Home/apartment                                 | 6. Assisted Living Unit  |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 3. Congregate housing                             | 7. Adult Family Care Home  |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 4. Residential Care Facility                      | 8. Adult Foster Home   |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
|   | 9. Other _____   |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| A. Location at time of assessment                 | <input type="text"/>   |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| B. Usual place of residence                       | <input type="text"/>   |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 15.   | USUAL LIVING ARRANGEMENT   | Lives with: (Check all that apply.)<br><table border="0"> <tr> <td>a. Alone</td> <td><input type="text"/></td> <td>e. With parents</td> <td><input type="text"/></td> </tr> <tr> <td>b. With spouse</td> <td><input type="text"/></td> <td>f. With friend</td> <td><input type="text"/></td> </tr> <tr> <td>c. With children</td> <td><input type="text"/></td> <td>g. With sibling</td> <td><input type="text"/></td> </tr> <tr> <td>d. With other residents</td> <td><input type="text"/></td> <td>h. Sig. other</td> <td><input type="text"/></td> </tr> <tr> <td></td> <td></td> <td>i. Other _____</td> <td><input type="text"/></td> </tr> </table>  |                      | a. Alone  | <input type="text"/> | e. With parents              | <input type="text"/>    | b. With spouse           | <input type="text"/>      | f. With friend               | <input type="text"/> | c. With children                             | <input type="text"/> | g. With sibling                   | <input type="text"/> | d. With other residents     | <input type="text"/> | h. Sig. other    | <input type="text"/> |                    |                      | i. Other _____ | <input type="text"/> |                    |                      |  |  |
| a. Alone  | <input type="text"/>   | e. With parents  | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| b. With spouse                                    | <input type="text"/>   | f. With friend   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| c. With children                                  | <input type="text"/>   | g. With sibling  | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| d. With other residents                           | <input type="text"/>   | h. Sig. other  | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
|   |  | i. Other _____   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 16.   | NO. IN HOUSEHOLD (Incl. applicant)   | Other than in institution/residential care facilities <input type="text"/>   |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 17.   | RESPONSIBILITY/LEGAL GUARDIAN (For only those items with supporting documentation) | (Check all that apply.)<br><table border="0"> <tr> <td>a. Legal guardian</td> <td><input type="text"/></td> <td>d. Family member responsible</td> <td><input type="text"/></td> </tr> <tr> <td>b. Other legal oversight</td> <td><input type="text"/></td> <td>e. Applicant responsible</td> <td><input type="text"/></td> </tr> <tr> <td>c. Durable power attorney/ health care proxy</td> <td><input type="text"/></td> <td>f. Other</td> <td><input type="text"/></td> </tr> <tr> <td></td> <td></td> <td>g. Unknown</td> <td><input type="text"/></td> </tr> </table>  |                      | a. Legal guardian                                 | <input type="text"/> | d. Family member responsible | <input type="text"/>    | b. Other legal oversight | <input type="text"/>      | e. Applicant responsible     | <input type="text"/> | c. Durable power attorney/ health care proxy | <input type="text"/> | f. Other                          | <input type="text"/> |                             |                      | g. Unknown       | <input type="text"/> |                    |                      |                |                      |                    |                      |  |  |
| a. Legal guardian                                 | <input type="text"/>   | d. Family member responsible   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| b. Other legal oversight                          | <input type="text"/>   | e. Applicant responsible   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| c. Durable power attorney/ health care proxy      | <input type="text"/>   | f. Other   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
|   |  | g. Unknown   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| 18.   | ADVANCED DIRECTIVES (For only those items with supporting documentation)           | (Check all that apply.)<br><table border="0"> <tr> <td>a. Living will</td> <td><input type="text"/></td> <td>f. Feeding restrictions</td> <td><input type="text"/></td> </tr> <tr> <td>b. Do not resuscitate</td> <td><input type="text"/></td> <td>g. Medication restrictions</td> <td><input type="text"/></td> </tr> <tr> <td>c. Do not hospitalize</td> <td><input type="text"/></td> <td>h. Other _____</td> <td><input type="text"/></td> </tr> <tr> <td>d. Organ donation</td> <td><input type="text"/></td> <td>i. NONE OF ABOVE</td> <td><input type="text"/></td> </tr> <tr> <td>e. Autopsy request</td> <td><input type="text"/></td> <td></td> <td></td> </tr> </table>  |                      | a. Living will                                    | <input type="text"/> | f. Feeding restrictions      | <input type="text"/>    | b. Do not resuscitate    | <input type="text"/>      | g. Medication restrictions   | <input type="text"/> | c. Do not hospitalize                        | <input type="text"/> | h. Other _____                    | <input type="text"/> | d. Organ donation           | <input type="text"/> | i. NONE OF ABOVE | <input type="text"/> | e. Autopsy request | <input type="text"/> |                |                      |                    |                      |  |  |
| a. Living will                                    | <input type="text"/>   | f. Feeding restrictions  | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| b. Do not resuscitate                             | <input type="text"/>   | g. Medication restrictions   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| c. Do not hospitalize                             | <input type="text"/>   | h. Other _____   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| d. Organ donation                                 | <input type="text"/>   | i. NONE OF ABOVE   | <input type="text"/> |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |
| e. Autopsy request                                | <input type="text"/>   |  |                      |   |                      |                              |                         |                          |                           |                              |                      |  |                      |                                   |                      |                             |                      |                  |                      |                    |                      |                |                      |                    |                      |  |  |

|   |   |
|---|---|
| 19. CONTACTS  |   |
| A. Name _____<br>Address _____<br>Relationship _____<br>Telephone _____ Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No | B. Name _____<br>Address _____<br>Relationship _____<br>Telephone _____ Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. REFERRING PHYSICIAN _____   |   |
| Address _____   |   |
| Telephone _____   |   |
| Homebound 0 - No 1 - Yes <input type="checkbox"/>   |   |
| CONTINUING PHYSICIAN _____  |   |
| Address _____   |   |
| Telephone _____   |   |

# CLINICAL DETAIL

Agency Name: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Provider-Assessor #         -

Social Security #    -

Assessment Date   -   -

## SECTION A. PROFESSIONAL NURSING SERVICES

Use the following codes for section A.1-A.10 (every block should be coded with a response).

Person will need care that is or otherwise would be performed by or under the supervision of a registered professional nurse:

0. Condition/treatment not present in the last 7 days.

1. 1-2 days a week

2. 3-4 days week

3. 5-6 days week

4. 7 days week

5. Once a month

6. At least once every 8 hours/7 days a week(used for Extended PDN only)

|    |                           |   |                            |
|----|---------------------------|---|----------------------------|
| 1. | INJECTIONS/<br>IV FEEDING | Injections/IV feeding for an unstable condition (excluding daily insulin for a person whose diabetes is under control):<br>a. Intraarterial injection<br>b. Intramuscular injection<br>c. Subcutaneous injection<br>d. Intravenous injection<br>e. Intravenous feeding (Parenteral or IV feeding.)  | a<br>b<br>c<br>d<br>e      |
| 2. | FEEDING TUBE              | Feeding tube for a new/recent (within 30 days) or an unstable condition:<br>Insertion date: _____<br>a. Nasogastric tube<br>b. Gastrostomy tube<br>c. Jejunostomy tube  | a<br>b<br>c                |
| 3. | SUCTIONING/<br>TRACH CARE | a. Nasopharyngeal suctioning<br>b. Tracheostomy care for a new/recent (within 30 days) or an unstable condition<br>Start date: _____  | a<br>b                     |
| 4. | TREATMENT/<br>DRESSINGS   | Treatment and/or application of dressings for one of the following conditions for which the physician has prescribed irrigation, application of medications, or sterile dressings and which requires the skills of an RN:<br>a. Stage 3 or 4 decubitus ulcers<br>b. Open surgical site<br>c. 2nd or 3rd degree burns<br>d. Stasis ulcer<br>e. Open lesions other than stasis/pressure ulcers or cuts (including but not limited to fistulas, tube sites and tumor erosions)<br>f. Other _____ | a<br>b<br>c<br>d<br>e<br>f |
| 5. | OXYGEN                    | Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) condition.<br>Start date: _____   | <input type="text"/>       |
| 6. | ASSESSMENT/<br>MANAGEMENT | Professional nursing assessment, observation and management required for <u>unstable</u> medical conditions. Observation must be needed at least once every 8 hours. Specify condition and code for applicant's need.<br>Please specify _____<br>_____  | <input type="text"/>       |
| 7. | CATHETER                  | Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.   | <input type="text"/>       |
| 8. | COMATOSE                  | Professional care is needed to manage a comatose condition.   | <input type="text"/>       |
| 9. | VENTILATOR/<br>RESPIRATOR | Care is needed to manage ventilator/respirator equipment.   | <input type="text"/>       |

|     |  |   |
|-----|--|---|
| 10. | UNCONTROLLED SEIZURE DISORDER                        | Direct assistance from others is needed for safe management of an uncontrolled seizure disorder. <input type="text"/>   |
| 11. | THERAPY-THERAPIES PROVIDED BY A QUALIFIED THERAPIST. | (Indicate the number of days per week for each therapy required. Enter 0 if none.)<br><br><b>Days per Week</b><br>a. Physical therapy _____<br>b. Speech/language therapy _____<br>c. Occupational therapy _____<br>d. Respiratory therapy _____<br><br>Total # of days of therapy per week: <input type="text"/> |
| 12. | THERAPY  | Is therapy required at least once a month for any of the following: physical, speech/language, occupational or respiratory therapy?<br>0 - NO 1 - YES <input type="text"/>  |
| 13. | ASSESSMENT/MANAGEMENT                                | Professional nursing assessment, observation and management of a medical condition once a month. Specify condition and code for applicant's need.<br>Please specify _____<br>0 - NO 1 - YES <input type="text"/>  |

## SECTION B. SPECIAL TREATMENTS AND THERAPIES

|    |                               |  |  |
|----|-------------------------------|--|--|
| 1. | TREATMENTS-CHRONIC CONDITIONS | Code for number of days care would be performed by or under the supervision of a registered nurse.<br>0. Not required<br>1. 1-2 days/week<br>2. 3 or more days/week<br>3. Once a month<br><br>Professional nursing care and monitoring for administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders.<br>a. Medications via tube<br>b. Tracheostomy care-chronic stable<br>c. Urinary catheter change<br>d. Urinary catheter irrigation<br>e. Veni puncture by RN<br>f. Monthly injections<br>g. Barrier dressings for Stage 1 or 2 ulcers<br>h. Chest PT by RN<br>i. O <sub>2</sub> therapy by RN for chronic unstable condition<br>j. Other _____ | a.<br>b.<br>c.<br>d.<br>e.<br>f.<br>g.<br>h.<br>i.<br>j. |
| 2. | TREATMENTS/PROCEDURES         | Code for number of days professional nursing is required.<br>0. Not required<br>1. 1-2 days/week<br>2. 3 or more days/week<br>3. Once a month<br><br>a. Chemotherapy<br>b. Radiation Therapy<br>c. Hemodialysis<br>d. Peritoneal Dialysis  | a.<br>b.<br>c.<br>d.                                     |

Agency Name: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Provider-Assessor #                    Social Security #            Assessment Date          **SECTION C. COGNITION**

|     |  |  |
|-----|--|--|
| 1.  | <b>MEMORY</b>  | (Recall of what was learned or known)<br>0-Memory OK 1-Memory problems<br>a. Short-term memory — seems/appears to recall after 5 minutes <input type="text"/><br>b. Long-term memory — seems/appears to recall long past <input type="text"/>  |
| 2.  | <b>MEMORY/ RECALL ABILITY</b>  | (Check all that person normally able to recall during last 7 days; 24-48 hrs. if in hospital)<br>a. Current season <input type="text"/> a<br>b. Location of own room <input type="text"/> b<br>c. Names/faces <input type="text"/> c<br>d. Where he/she is <input type="text"/> d<br>e. None of the above were recalled <input type="text"/> e |
| 3.  | <b>COGNITIVE SKILLS FOR DAILY DECISION - MAKING</b>  | Made decisions regarding tasks of daily life.<br>0.Independent—decisions consistent/reasonable<br>1.Modified independence—some difficulty in new situations only<br>2.Moderately impaired—decisions poor; cues/supervision required <input type="text"/><br>3.Severely impaired—never/rarely made decisions                                    |
| 4A. | Is professional nursing assessment, observation and management required at least 3 days/week to manage all the above cognitive patterns?<br>0 - NO 1 - YES <input type="text"/><br>If 4A = 1 (YES), proceed to 5. If 4A = 0 (NO) and person meets the cognitive impairment threshold as defined in Chapter II, Section 67 of the MaineCare Benefits Manual, then go to page 2A and complete Section C.4B of the Supplemental Screening Tool. |  |
| 5.  | Is professional nursing assessment, observation and management required once a month to manage all the above cognitive patterns?<br>0 -NO 1 - YES <input type="text"/>   |  |

**SECTION D. PROBLEM BEHAVIOR**

|     |  |                      |                      |
|-----|--|----------------------|----------------------|
| 1.  | Column A Codes: Code for the frequency of behavior in last 7 days<br>0. Behavior not exhibited in last 7 days<br>1. Behavior of this type occurred 1 to 3 days in last 7 days<br>2. Behavior of this type occurred 4 - 6 days, but less than daily<br>3. Behavior of this type occurred daily<br><br>Column B Codes: Alterability of behavioral symptoms<br>0. Not present or easily altered<br>1. Behavior not easily altered               | A<br>FREQUENCY       | B<br>ALTERABILITY    |
|     | a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)  | <input type="text"/> | <input type="text"/> |
|     | b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)   | <input type="text"/> | <input type="text"/> |
|     | c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)  | <input type="text"/> | <input type="text"/> |
|     | d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)   | <input type="text"/> | <input type="text"/> |
|     | e. RESISTS CARE (resisted taking medications/injections, ADL assistance or eating)   | <input type="text"/> | <input type="text"/> |
| 2A. | Is professional nursing assessment, observation and management required at least 3 days/week to manage the behavior problems—items a-d?<br>0 - NO 1 - YES <input type="text"/><br>If 2A = 1 (YES), proceed to 3. If 2A = 0 (NO) and person meets the behavioral impairment threshold as defined in Chapter II, Section 67 of the MaineCare Benefits Manual, then go to page 2A and complete Section D.2B of the Supplemental Screening Tool. |                      |                      |
| 3.  | Is professional nursing assessment, observation and management required once a month to manage the above behavior problems?<br>0 -NO 1 - YES <input type="text"/>  |                      |                      |

**SECTION E. PHYSICAL FUNCTIONING/STRUCTURAL PROBLEMS**

|  |  |                      |                      |
|--|--|----------------------|----------------------|
| 1. <b>ADL SELF-PERFORMANCE</b><br>(Code for PERFORMANCE during last 7 days (24-48 hrs. if in hospital) – not including setup.)<br>0. INDEPENDENT — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days.<br>1. SUPERVISION — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days.<br>2. LIMITED ASSISTANCE — Person highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times — OR — Limited assistance (as just described) plus weight-bearing support 1 or 2 times during the last 7 days.<br>3. EXTENSIVE ASSISTANCE — While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:<br>— Weight-bearing support<br>— Full staff/caregiver performance during part (but not all) of last 7 days.<br>4. TOTAL DEPENDENCE — Full staff/caregiver performance of activity during ENTIRE 7 days.<br>5. CUEING — Spoken instructions or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.<br>8. ACTIVITY DID NOT OCCUR during entire 7 days. |  | 1                    | 2                    |
| 2. <b>ADL SUPPORT PROVIDED</b> — (Code for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD during last 7 days (24-48 hours if person is in hospital); code regardless of person's self-performance classification.)<br>0. No setup or physical help from staff<br>1. Setup help only<br>2. One-person physical assist<br>3. Two+ persons physical assist<br>5. CUEING-Cueing support required 7 days a week<br>8. Activity did not occur during entire 7 days.  |  | SELF-PERFORMANCE     | SUPPORT              |
| a. <b>BED MOBILITY</b>   | How person moves to and from lying position, turns side to side, and positions body while in bed   | <input type="text"/> | <input type="text"/> |
| b. <b>TRANSFER</b>   | How person moves between surfaces — to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)   | <input type="text"/> | <input type="text"/> |
| c. <b>LOCOMOTION</b>   | How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair   | <input type="text"/> | <input type="text"/> |
| d. <b>DRESSING</b>   | How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis   | <input type="text"/> | <input type="text"/> |
| e. <b>EATING</b>   | How person eats and drinks (regardless of skill)   | <input type="text"/> | <input type="text"/> |
| f. <b>TOILET USE</b>   | How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes  | <input type="text"/> | <input type="text"/> |
| g. <b>PERSONAL HYGIENE</b>   | How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)  | <input type="text"/> | <input type="text"/> |
| 3. <b>WALKING</b>  | a. How person walks for exercise only<br>b. How person walks around own room<br>c. How person walks within home<br>d. How person walks outside   | <input type="text"/> | <input type="text"/> |
| 4. <b>BATHING</b>  | How person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). (Code for most dependent in self performance and support. Bathing Self-Performance codes appear below.)<br>0. Independent—No help provided<br>1. Supervision—Oversight help only<br>2. Physical help limited to transfer only<br>3. Physical help in part of bathing activity<br>4. Total dependence<br>5. CUEING—Cueing support required 7 days a week<br>8. Activity did not occur during entire 7 days. | 1                    | 2                    |
|  |  | SELF-PERFORMANCE     | SUPPORT              |

Agency Name: \_\_\_\_\_

Provider-Assessor # -

Applicant Name: \_\_\_\_\_

Social Security # Assessment Date **SECTION C.4B. COGNITION***Enter the code that most accurately describes the person's cognition for the last 7 days.***1. MEMORY FOR EVENTS:**

- 0 Can recall details and sequences of recent experiences and remember names of meaningful acquaintances.
- 1 Cannot recall details or sequences of recent events or remember names of meaningful acquaintances.
- 2 Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting.
- 3 Cannot recall entire events or name of spouse or other living partner even with prompting.

**2. MEMORY AND USE OF INFORMATION:**

- 0 Does not have difficulty remembering and using information. Does not require directions or reminding from others.
- 1 Has minimal difficulty remembering and using information. Requires direction and reminding from others one to three times per day. Can follow simple written instructions.
- 3 Has difficulty remembering and using information. Requires direction and reminding from others four or more times per day. Cannot follow written instructions.
- 4 Cannot remember or use information. Requires continual verbal reminding.

**3. GLOBAL CONFUSION:**

- 0 Appropriately responsive to environment.
- 1 Nocturnal confusion on awakening.
- 2 Periodic confusion during daytime.
- 3 Nearly always confused.

**4. SPATIAL ORIENTATION:**

- 0 Oriented, able to find and keep his/her bearings.
- 1 Spatial confusion when driving or riding in local community.
- 2 Gets lost when walking neighborhood.
- 3 Gets lost in own home or present environment.

**5. VERBAL COMMUNICATION:**

- 0 Speaks normally.
- 1 Minor difficulty with speech or word-finding difficulties.
- 2 Able to carry out only simple conversations.
- 3 Unable to speak coherently or make needs known.

**C.4B TOTAL COGNITIVE SCORE** 

Return to Section C5 on page 2.

**SECTION D.2B. BEHAVIOR***Enter the code that most accurately describes the person's behavior for the last 7 days.***1. SLEEP PATTERNS:**

- 0 Unchanged from "normal" for the consumer.
- 1 Sleeps noticeably more or less than "normal."
- 3 Restless, nightmares, disturbed sleep, increased awakenings.
- 4 Up wandering for all or most of the night, inability to sleep.

**2. WANDERING:**

- 0 Does not wander.
- 1 Does not wander. Is chair bound or bed bound.
- 2 Wanders within the facility or residence and may wander outside, but does not jeopardize health and safety.
- 3 Wanders within the facility or residence. May wander outside, health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.
- 4 Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

**3. BEHAVIORAL DEMANDS ON OTHERS:**

- 0 Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.
- 1 Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.
- 3 Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The consumer's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing.
- 4 Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The consumer's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing even given training for the caregiver.

**4. DANGER TO SELF AND OTHERS:**

- 0 Is not disruptive or aggressive, and is not dangerous.
- 1 Is not capable of harming self or others because of mobility limitations (is bed bound or chair bound).
- 2 Is sometimes (1 to 3 times in the last 7 days) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment.
- 3 Is frequently (4 or more times during the last 7 days) disruptive or aggressive, or is frequently extremely agitated or anxious; and professional judgment is required to determine when to administer prescribed medication.
- 5 Is dangerous or physically abusive, and even with proper evaluation and treatment may require physician's orders for appropriate intervention.

**5. AWARENESS OF NEEDS/JUDGMENT:**

- 0 Understands those needs that must be met to maintain self care.
- 1 Sometimes (1 to 3 times in the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 2 Frequently (4 or more times during the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 3 Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.

**D.2B TOTAL BEHAVIOR SCORE** 

Return to Section D3 on page 2.





Agency Name: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Provider-Assessor # 

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**SECTION P. INSTRUMENTAL ACTIVITIES OF DAILY LIVING****1. IADL SELF-PERFORMANCE CODES:**

0. INDEPENDENT: (with/without assistive devices)—No help provided.
1. INDEPENDENT WITH DIFFICULTY: Person performed task, but did so with difficulty or took a great amount of time to do so.
2. ASSISTANCE/DONE WITH HELP: Person involved in activity but help (including supervision, reminders, and/or physical "hands-on" help) was provided.
3. DEPENDENT/DONE BY OTHERS:  
Full performance of the activity was done by others The person was not involved at all each time the activity was performed.
8. Activity did not occur.

**2. IADL SUPPORT CODES:**

0. No support provided.
1. Supervision/cueing provided.
2. Set-up help only.
3. Physical assistance was provided.
4. Total dependence—the person was not involved at all when the activity was performed.
8. Activity did not occur.

|                  | 1 | 2 |
|------------------|---|---|
| SELF-PERFORMANCE |   |   |
| SUPPORT          |   |   |

|   |   |            |             |
|---|---|------------|-------------|
| 1. DAILY INSTRUMENTAL ACTIVITIES<br><br><i>Code for level of independence based on person's involvement in the activity in the last 7 days</i>                  | a. Meal Preparation: Prepared breakfast and light meals.  |            |             |
|   | b. Main Meal Preparation: Prepared or received main meal<br><input type="checkbox"/> Meals on Wheels _____ times per week   |            |             |
|   | c. Telephone: Used telephone as necessary, e.g., able to contact people in an emergency.  |            |             |
|   | d. Light Housework: Did light housework such as dishes, dusting (on daily basis), making own bed.   |            |             |
| 2. OTHER INSTRUMENTAL ACTIVITIES OF DAILY LIVING<br><br><i>Code for level of independence based on person's involvement in the activity in the last 14 days</i> | a. Managing Finances: Managed own finances, including banking, handling checkbook, paying bills.  |            |             |
|   | b. Routine Housework: Did routine housework such as vacuuming, cleaning floors, trash removal, cleaning bathroom, as needed.  |            |             |
|   | c. Grocery Shopping: Did grocery shopping as needed (excluding transportation).   |            |             |
|   | d. Laundry:<br>Indicate: <input type="checkbox"/> in home <input type="checkbox"/> out of home<br>Did laundry in home or at laundry facility (excluding transportation).      |            |             |
| 3. TRANSPORTATION<br><br><i>Check all that apply for level of independence based on person's involvement in the activity in the last 30 days.</i>               | <input type="checkbox"/> a. Person drove self or used public transportation independently to get to medical, dental appointments, necessary engagements, or other activities. |            |             |
|   | <input type="checkbox"/> b. Person needed arrangement for transportation to medical, dental appointments, necessary engagements, or other activities.                         |            |             |
|   | <input type="checkbox"/> c. Person needed transportation to medical, dental appointments, necessary engagements, or other activities.   |            |             |
|   | <input type="checkbox"/> d. Person needed escort to medical, dental appointments, necessary engagements, or other activities.   |            |             |
|   | <input type="checkbox"/> e. Activity did not occur.   |            |             |
| 4. PRIMARY MODES OF LOCOMOTION  | <i>Code for the primary mode of locomotion for (a) indoors and (b) outdoors from the following list:</i>  |            |             |
|   | 0. No assistive device<br>1. Cane<br>2. Walker/crutch<br>3. Scooter (e.g. Amigo)<br>4. Wheelchair<br>5. Activity does not occur   | a. Indoors | b. Outdoors |

**SECTION Q. ENVIRONMENTAL ASSESSMENT**

|    |  |   |    |
|----|--|---|----|
| 1. | If person resides in a facility such as a NF, RCF, or hospital, check here and proceed to Section R.   |   |    |
| 2. | HOME ENVIRONMENT<br><br><i>(Check any of the following that makes home environment hazardous or uninhabitable. If none apply, check NONE OF ABOVE. If temporarily in institution, base assessment on home visit)</i> | a. Lighting (including adequacy of lighting, exposed wiring)  | a. |
|    |  | b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)   | b. |
|    |  | c. Bathroom and toiletroom environment (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)  | c. |
|    |  | d. Kitchen environment (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)   | d. |
|    |  | e. Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)  | e. |
|    |  | f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)  | f. |
|    |  | g. Access to home (e.g., difficulty entering/leaving home)  | g. |
|    |  | h. NONE OF ABOVE  | h. |
| 3. | TRADE OFFS<br><i>Check all that apply.</i>   | Because of limited funds, during the last month, person made trade-offs in purchasing the following:<br><br><input type="checkbox"/> a. home heat<br><input type="checkbox"/> b. adequate food<br><input type="checkbox"/> c. necessary physician care<br><input type="checkbox"/> d. prescribed medications<br><input type="checkbox"/> e. home care.<br><input type="checkbox"/> f. NONE OF ABOVE |    |

**SECTION R. MOOD**

|   |   |   |    |
|---|---|---|----|
| 1.  | INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD   | <i>Code for behavior in last 30 days irrespective of the assumed cause.</i><br>0. Indicator not exhibited<br>1. Indicator of this type exhibited up to 5 days a week<br>2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)                            |    |
| VERBAL EXPRESSIONS OF DISTRESS  | a. Person made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."<br>b. Repetitive questions—e.g., "Where do I go? What do I do?"<br>c. Repetitive verbalizations—e.g., calling out for help. ("God help me.")<br>d. Persistent anger with self or others—e.g., easily annoyed; anger at placement in nursing home; anger at care received<br>e. Self-deprecation—e.g., "I am nothing; I am of no use to anyone."<br>f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others<br>g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack | h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions   | h. |
|   |   | i. Repetitive anxious complaints/concerns (non-health related)—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues  | i. |
|   |   | <b>SLEEP-CYCLE ISSUES</b>   |    |
|   |   | j. Unpleasant mood in morning   | j. |
|   |   | k. Insomnia/change in usual sleep pattern   | k. |
|   |   | <b>LOSS OF INTEREST</b>   |    |
|   |   | l. Sad, pained, worried facial expressions—e.g., furrowed brows   | l. |
|   |   | m. Crying, tearfulness  | m. |
|   |   | n. Repetitive physical movements—e.g., pacing, hand-wringing, restlessness, fidgeting, picking  | n. |
|   |   | <b>LOSS OF INTEREST</b>   |    |
| o. Withdrawal from activities of interest—e.g., no interest in longstanding activities or being with family/friends | o.  |   |    |
| p. Reduced social interaction   | p.  |   |    |
| 2.  | MOOD PERSISTENCE  | One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up," console or reassure the person over the last 7 days.<br>0. No mood indicators<br>1. Indicators present, easily altered<br>2. Indicators present, not easily altered |    |
| 3.  | MOOD  | Person's current mood status compared to person's status 180 days ago.<br>0. No change<br>1. Improved<br>2. Declined  |    |



## Page 2 of 7

Applicant Name: \_\_\_\_\_

|                   |  |  |  |   |  |  |   |  |  |  |
|-------------------|--|--|--|---|--|--|---|--|--|--|
| Social Security # |  |  |  | — |  |  | — |  |  |  |
|-------------------|--|--|--|---|--|--|---|--|--|--|

|       |  |   |
|-------|--|---|
| H.1.A | In Section E, Physical Functioning/Structural Problems, were d., e., f., and 4 dressing, eating, toilet use, and bathing) all coded with a 5 (cueing) in self-performance AND support?   | Yes ____ No ____                                  |
| H.1.B | In Section E, Physical Functioning/Structural Problems, how many ADLs from the following 7 ADLs: bed mobility, transfer, locomotion, eating, toilet use, dressing, or bathing were coded with a 2, 3 or 4 in self-performance AND a 2 or 3 in support?   | <input type="text"/>                              |
| H.1.C | In Section A, items 1-11, Professional Nursing Services, how many boxes were coded with at least a 1 (needed nursing service at least one day a week)?   | <input type="text"/>                              |
| H.1.D | In Section P, Instrumental Activities of Daily Living, how many IADLs from items 1b. main meal preparation, 2b. routine house work, 2c. grocery shopping, or 2d. laundry were coded with a 2 or 3 (assistance/done with help or dependent/done by others) in self-performance AND a 3 or 4 in support? | <input type="text"/>                              |
|       |  | <b>Sum H.1.B +C +D Total</b> <input type="text"/> |
| H.1.E | If the answer to H.1. (cueing) is "YES," score this section with a "1."  | <input type="text"/>                              |
| H.1.F | If the person requires assistance with <b>at least one ADL</b> from the following 7 ADLs: bed mobility, transfer, locomotion, eating, toilet use, dressing, or bathing, AND the TOTAL score from H.1.B+C+D above is equal to or greater than 3, score this section with a "1."                         | <input type="text"/>                              |

|   |   |   |
|---|---|---|
| H.2   | If person is medically eligible for Level II Private Duty Nursing (R.2D on page 5 of 7 under Eligibility Determination), score this section with a “1”. | <div style="border: 1px solid black; width: 100px; height: 100px;"></div> |
| <i>If H.2 is scored with a “1”, the consumer appears to be functionally eligible for Home Based Care – Level 2.</i> |   |   |

H.3.A In Section E, Physical Functioning/Structural Problems, are at least 2 ADLs from the following: bed mobility, transfer, locomotion, eating, or toilet use coded with a 2, 3, or 4 in self-performance and a 2 or 3 in support **AND** in Section P, Instrumental Activities of Daily Living, are at least 3 IADLs from the following:  
1.b main meal preparation, 2.b routine housework, 2.c grocery shopping, 2.d laundry, coded with a 2 or 3 in self-performance and a 3 or 4 in support? Yes \_\_\_\_ No \_\_\_\_

H.3 If the answer to H.3.A is Yes, score this section with a “1”.

***If H.3 is scored with a “1”, the consumer appears to be functionally eligible for Home Based Care – Level 3.***

|     |  |   |
|-----|--|---|
| H.4 | <p>If person is medically eligible for NF Level of Care (NF.7 on page 7 of 7 under Eligibility Determination), score this section with a "1".</p> <p><i>If H.4 is scored with a "1", the consumer appears to be functionally eligible for Home Based Care – Level 4.</i></p> | <div style="border: 1px solid black; width: 50px; height: 30px; margin: 0 auto;"></div> |
|-----|--|---|

# ELIGIBILITY DETERMINATION

Page 3 of 7

Agency Name: \_\_\_\_\_ Applicant Name: \_\_\_\_\_

Provider-Assessor #           -    Social Security #    -

Assessment Date:    -    -

## COGNITIVE CAPACITY FOR CONSUMER DIRECTED SERVICES

Does consumer have a Legal Guardian (Section A.17.a)?

Yes \_\_\_\_ No \_\_\_\_

If 'yes', consumer does have a legal guardian, do not continue scoring for consumer-directed services. Consumer is not eligible for Consumer Directed Services.

If 'no', consumer does not have a legal guardian, then continue scoring for cognitive capacity.

### Ability to Self-direct Indicators:

1. Decision Making skills (Section C.3) = 0 or 1 Yes \_\_\_\_ No \_\_\_\_
2. Making Self Understood (Section I.3) = 0, 1, or 2 Yes \_\_\_\_ No \_\_\_\_
3. Ability to Understand Others (Section I.4) = 0, 1, or 2 Yes \_\_\_\_ No \_\_\_\_
4. Managing Finances (Section P.2.a.1)
- a. in Self Performance = 0, 1, or 2 Yes \_\_\_\_ No \_\_\_\_
- b. in Support = 0, 1, 2, or 3 Yes \_\_\_\_ No \_\_\_\_

CC.1 If all the answers to the above questions are "Yes" then score this section with a "1".

Person appears to have cognitive capacity to self-direct their care.

## MaineCare CONSUMER DIRECTED PCA SERVICES

P.1 In Section E, Physical Functioning/Structural Problems, are at least 2 ADLs from the following: bed mobility, transfer, locomotion, dressing, eating, toilet use, or bathing coded with a 2, 3, or 4 in self-performance and a 2 or 3 in support? Yes \_\_\_\_ No \_\_\_\_

P.2 If the answer to P.1 is Yes, AND CC.1 (Cognitive Capacity) is scored with a "1", then score this section with a "1".

If P.2 is scored with a "1", the consumer appears to be functionally eligible for MaineCare Consumer Directed PCA Services.

## CONSUMER DIRECTED HOME BASED CARE

CDH.1 In Section E, Physical Functioning/Structural Problems, how many ADLs from the following 7 ADLs: bed mobility, transfer, locomotion, eating, toilet use, dressing, or bathing were coded with a 2, 3 or 4 in self-performance AND a 2 or 3 in support?

CDH.2 In Section A, items 1-11, Professional Nursing Services, how many boxes were coded with at least a 1 (needed nursing service at least one day a week)?

CDH.3 In Section P, Instrumental Activities of Daily Living, how many IADLs from items 1b. main meal preparation, 2b. routine house work, 2c. grocery shopping, or 2d. laundry were coded with a 2 or 3 (assistance/done with help or dependent/done by others) in self-performance and a 3 or 4 in support?

Sum CDH. 1+2 +3 = Total

CDH.4 If the person requires assistance with at least one ADL from CDH.1, AND the TOTAL score above is equal to or greater than 3, score this section with a "1".

CDH.5 If CDH.4 is "1" AND CC.1 (Cognitive Capacity) is scored with a "1", then score this section with a "1".

If CDH.5 is scored with a "1", the consumer appears to be functionally eligible for Consumer Directed Home Based Care Services.

## MaineCare PHYSICALLY DISABLED HCB

PDW. 1 Is person medically eligible for NF Level of Care (NF.7 on page 7 of 7 under Eligibility Determination)? Yes \_\_\_\_ No \_\_\_\_

PDW.2 If the answer to PDW.1 is Yes, AND CC.1 (Cognitive Capacity) is scored with a '1', then score this section with a "1".

If PDW.2 is scored with a "1", the consumer appears to be functionally eligible for MaineCare Physically Disabled HCBS.

# ELIGIBILITY DETERMINATION

Agency Name: \_\_\_\_\_ Applicant Name: \_\_\_\_\_

Provider-Assessor #           -    Social Security #    -   -

Assessment Date:    -    -

## ADULT FAMILY CARE HOMES - LEVEL 1

### Cueing/Limited Assistance

AF.1. a. In Section E, (Physical Functioning/Structural Problems), are the ADLs from items d, e, f, and 4 (dressing, eating, toilet use, and bathing) coded with a 5 (cueing required 7 days a week) in self-performance and 2,3, or 5 in support? OR Yes \_\_\_\_ No \_\_\_\_

b. In Section E, Physical Functioning/Structural Problems, were 2 or more of the following 7 ADLs: bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing coded with a 2, 3 or 4 in self-performance and coded with a 2 or 3 in support? Yes \_\_\_\_ No \_\_\_\_

If the answer to either of these questions is "YES," score this section with a "1." The consumer appears to be eligible for Level 1 of Adult Family Care Homes. ☐

## ADULT FAMILY CARE HOMES - LEVEL 2

### Extensive Assistance

AF.2. a. In Section E, (Physical Functioning/Structural Problems), is at least one ADL from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 3 or 4 (extensive assistance or total dependence) in self-performance and a 2 or 3 in support? AND Yes \_\_\_\_ No \_\_\_\_

b. In Section E, (Physical Functioning/Structural Problems), are at least two (2) additional ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes \_\_\_\_ No \_\_\_\_

If the answer to both of these questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 2 of Adult Family Care Homes. ☐

### Cognitive Impairment

AF.3. a. Is Section C1a (short term memory) coded with a 1? Yes \_\_\_\_ No \_\_\_\_

b. In Section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d or is C2e, None of the Above, checked (Person is able to recall no more than 2 items)? Yes \_\_\_\_ No \_\_\_\_

c. Is Section C3 coded with a 2 or 3? Yes \_\_\_\_ No \_\_\_\_

d. In Section E, (Physical Functioning/Structural Problems), are 2 or 3 ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes \_\_\_\_ No \_\_\_\_

If the answer to all of the above questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 2 of Adult Family Care Homes. ☐

### Behavioral Symptoms

AF.4. a. In Section D, Problem Behavior, are one or more of the behaviors from items a, b and c (wandering, verbally abusive, physically abusive) coded with a 2 or 3? Yes \_\_\_\_ No \_\_\_\_

OR are at least 3 of the behaviors from items a, b, c and d coded with a 1 (behavior of this type occurred on 1-3 days only)? Yes \_\_\_\_ No \_\_\_\_

b. In Section E, (Physical Functioning/Structural Problems), are 2 or 3 ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes \_\_\_\_ No \_\_\_\_

If the answer to both of these questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 2 of Adult Family Care Homes. ☐

## ADULT FAMILY CARE HOMES - LEVEL 3

### Cognitive Impairment

AF.5. a. Is Section C1a (short term memory) coded with a 1? Yes \_\_\_\_ No \_\_\_\_

b. In Section C2 (memory recall) are only 1 or 2 boxes checked in C2a-C2d or is C2e, None of the Above, checked (Person is able to recall no more than 2 items)? Yes \_\_\_\_ No \_\_\_\_

c. Is Section C3 coded with a 2 or 3? Yes \_\_\_\_ No \_\_\_\_

d. In Section E, (Physical Functioning/Structural Problems), are at least 4 ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes \_\_\_\_ No \_\_\_\_

If the answer to all of the above questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 3 of Adult Family Care Homes. ☐

### Behavioral Symptoms

AF.6. a. In Section D, Problem Behavior, are one or more of the behaviors from items a, b and c (wandering, verbally abusive, physically abusive) coded with a 2 or 3? Yes \_\_\_\_ No \_\_\_\_

OR are at least 3 of the behaviors from items a, b, c and d coded with a 1 (behavior of this type occurred on 1-3 days only)? Yes \_\_\_\_ No \_\_\_\_

b. In Section E, (Physical Functioning/Structural Problems), are at least 4 ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes \_\_\_\_ No \_\_\_\_

If the answer to both of these questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 3 of Adult Family Care Homes. ☐

# ELIGIBILITY DETERMINATION

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Agency Name: \_\_\_\_\_ Applicant Name: \_\_\_\_\_  
 Provider-Assessor #         -      
 Social Security #    -   -      
 Assessment Date   -   -

## PDN/PCS LEVEL 1

**R.1.A** In Clinical Detail, Section E, Physical Functioning/Structural Problems, were **d, e, f and 4** (dressing, eating, toilet use, and bathing) all coded with a '5' (cueing) in **Self-Performance AND Support**?

Yes \_\_\_\_ No \_\_\_\_

**R.1.B** In Clinical Detail, Section E, Physical Functioning/Structural Problems, were 2 of the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in **Self-Performance AND a 2 or 3 in Support**?

Yes \_\_\_\_ No \_\_\_\_

**R.1.C** If the answer to either of these questions is 'yes,' then score this section with a '1'. Person appears to be eligible for **PDN-Level 1**.

## PDN/PCS NURSING SCORE

### Private Duty Nursing

RN.A. a. In Section A, Nursing Services, were any items 1-8 coded with a 1, 2, 3, or 5?

Yes \_\_\_\_ No \_\_\_\_

b. In Section A, item 9 (Ventilator/Respirator), did you code this response with a 1 or a 5?

Yes \_\_\_\_ No \_\_\_\_

c. In Section A, item 10 (uncontrolled seizures) did you code this with a 5 (care needed once a month)?

Yes \_\_\_\_ No \_\_\_\_

d. In Section A, was item 12, therapy, coded with a 1 (therapy needed once a month)?

Yes \_\_\_\_ No \_\_\_\_

e. In Section A, was item 13, Assessment/Management, coded with a 1 (assessment needed once a month)?

Yes \_\_\_\_ No \_\_\_\_

If the answer to any of these questions is "YES," then score this section with a "1."

### Professional Nursing Services

RN.B. In Section B.1 - B.2, Special Treatments and Therapies, were any boxes coded with a 1, 2, or 3?

Yes \_\_\_\_ No \_\_\_\_

If the answer is "YES," then score this section with a "1."

### Impaired Cognition

RN.C. a. Is Section C1a (short term memory) coded with a 1?

Yes \_\_\_\_ No \_\_\_\_

b. In Section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d or is C2e, None of the Above, checked (Person is able to recall no more than 2 items)?

Yes \_\_\_\_ No \_\_\_\_

c. Is Section C3 coded with a 2 or 3?

Yes \_\_\_\_ No \_\_\_\_

d. Is Section C5 coded with a 1 (i.e. is professional nursing assessment, observations and management required once a month to manage all the above cognitive patterns)?

Yes \_\_\_\_ No \_\_\_\_

If all the answers to the above questions are "YES," then score this section with a "1."

### Behavior Problems

RN.D. a. In Section D, Problem Behavior, are one or more of the behaviors a-d coded with a 2 or 3?

Yes \_\_\_\_ No \_\_\_\_

b. Is Section D3 coded with a 1 (i.e. is professional nursing assessment, observations and management required once a month to manage the above behavior problems)?

Yes \_\_\_\_ No \_\_\_\_

If the answer to both of these questions is "YES," then score this section with a "1."

RN.E. Compute the total PDN nursing score from questions RN.A., RN.B., RN.C. and RN.D.

If the Total nursing score is 1 or more, proceed. Otherwise, the person appears NOT to be medically eligible for PDN Level II or Level III.

## PDN/PCS LEVEL 2

**R.2.A** In Clinical Detail, Section E, Physical Functioning/Structural Problems, were **d, e, f, and 4** (dressing, eating, toilet use, and bathing) all coded with a '5' (cueing) in **Self-Performance AND Support**?

Yes \_\_\_\_ No \_\_\_\_

**R.2.B** In Clinical Detail, Section E, Physical Functioning/Structural Problems, were 2 of the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in **Self-Performance AND a 2 or 3 in Support**?

Yes \_\_\_\_ No \_\_\_\_

**R.2.C ADL Needs Score:** If the answer to either **R.2.A** or **R.2.B** is 'yes' then score this section with a '1'.

**R.2.D PDN-Level 2 Eligibility Determination (RN.E + R.2.C)**

Yes \_\_\_\_ No \_\_\_\_

a. In RN.E, is the PDN Nursing Score '1' or more?

Yes \_\_\_\_ No \_\_\_\_

b. In R.2.C, is the ADL Needs Score '1'?

If the answer to both of these questions is YES, score '1' in the box. The person appears to be eligible for **PDN-Level 2**. Otherwise, the person appears **NOT** to be eligible for **PDN-Level 2**.

## PDN/PCS LEVEL 3

**R.3.A** In Clinical Detail, Section E, Physical Functioning/Structural Problems, were 2 of the following 5 Shaded ADLs (bed mobility, transfer, locomotion, eating, toilet use) coded with a 2, 3, or 4 in **Self-Performance AND a 2 or 3 in Support**?

Yes \_\_\_\_ No \_\_\_\_

**R.3.B ADL Needs Score:** If the answer to **R.3.A** is 'yes' then score this section with a '1'.

**R.3.C PDN-Level 3 Eligibility Determination (RN.E + R.3.B)**

Yes \_\_\_\_ No \_\_\_\_

a. In RN.E, is the PDN Nursing Score '1' or more?

Yes \_\_\_\_ No \_\_\_\_

b. In R.3.B, is the ADL Needs Score '1'?

If the answer to both of these questions is YES, score '1' in the box. The person appears to be eligible for **PDN-Level 3**. Otherwise, the person appears **NOT** to be eligible for **PDN-Level 3**.

# ELIGIBILITY DETERMINATION

|  |  |
|--|--|
| Agency Name: _____   | Applicant Name: _____  |
| Provider-Assessor # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> | Social Security # <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Assessment Date: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>   |  |

| PDN/PCS Level V   |                                |
|---|--------------------------------|
| <b>EXP.1.</b> In Section A, was item 9 (Ventilator/Respirator) coded with a 4 (nursing services needed 7 days a week)?  | <b>Yes</b> ____ <b>No</b> ____ |
| <i>If the answer is YES, then person appears to be medically eligible for Extended PDN. Score 1 in the box.</i>   |                                |
| <i>If the answer is NO. then proceed to EXP.2.</i>  |                                |
| <b>EXP.2a.</b> In Section A, was one of the items from 1 (Injections/IV Feedings), 2 (Feeding Tube), 3 (Suctioning/Trach Care), 4 (Treatment/Dressings), 8 (Comatose), or 10 (Uncontrolled Seizure) coded with a 6 (service needed at least once every 8 hours, 7 days a week)? | <b>Yes</b> ____ <b>No</b> ____ |
| <b>2b.</b> In Section A, were 2 additional items from 1, 2, 3, 4, 8, or 10 coded with a 4?  | <b>Yes</b> ____ <b>No</b> ____ |
| <i>If the answer to BOTH 2a. and 2b. is YES, then person appears to be medically eligible for Extended PDN. Score 1 in the box.</i>   |                                |
| <i>If NO, then person appears to NOT be medically eligible for Extended PDN.</i>  |                                |
| <b>PDN Level VI -- MEDICATION SERVICES FOR PERSONS WITH SEVERE AND DISABLING MENTAL ILLNESS</b>   |                                |
| <b>R.10. a.</b> Is there a physician certification in the person's record verifying the person's eligibility or coverage for services under Section 17?   | <b>Yes</b> ____ <b>No</b> ____ |
| <b>b.</b> Has a physician certified that use of outpatient services is contraindicated for this person?   | <b>Yes</b> ____ <b>No</b> ____ |
| <i>If the answer to both of these questions is "YES", then score this section with a "1".</i>   |                                |
| <b>R.11. a.</b> In Section G, Medication, is G1a, Preparation/Administration, coded with a 6?   | <b>Yes</b> ____ <b>No</b> ____ |
| <b>b.</b> In Section G, Medication, is G1b, Compliance, coded with a 4?   | <b>Yes</b> ____ <b>No</b> ____ |
| <i>If the answer to either of these questions is "YES", then score this section with a "1".</i>   |                                |
| <i>If the answer to both R.10. and R.11. is scored with a "1" then this person appears to be eligible for Medication Services under Private Duty Nursing. Otherwise, this person appears NOT to be eligible for Medication Services.</i>  |                                |
| <b>PDN Level VII -- VENIPUNCTURE ONLY SERVICES</b>  |                                |
| <b>R.12. a.</b> Is there a physician order in the person's record for <u>only</u> venipuncture services on a regular basis?   | <b>Yes</b> ____ <b>No</b> ____ |
| <b>b.</b> Has a physician certified that use of outpatient services is contraindicated for this person?   | <b>Yes</b> ____ <b>No</b> ____ |
| <b>c.</b> In Section B, Special Treatments and Therapies, is B.1.e, Venipuncture, coded with a 1, 2, or 3?  | <b>Yes</b> ____ <b>No</b> ____ |
| <i>If the answers to R.12 a., b., and c. are "YES", then score this section with a "1". Person appears to be eligible for Venipuncture Services under Private Duty Nursing.</i>   |                                |

## Page 7 of 7

Agency Name:

Applicant Name:

Provider-Assessor #

Social Security #

Assessment Date

NF. 1. a. In Section A, Nursing Services, items 1-8, did you code any of the responses with a 4 (i.e., services needed 7 days/week)? Yes \_\_\_ No \_\_\_

b. In Section A, item 9 (Ventilator/Respirator) did you code this response with a 2, 3 or 4 (treatment needed at least 3 days/week)? Yes \_\_\_ No \_\_\_

c. In Section A, item 10 (Uncontrolled Seizure), did you code this response with a 1, 2, 3 or 4 (care needed at least once/week)? Yes \_\_\_ No \_\_\_

d. In Section A, item 11 (Therapies), was the total number of days of therapy 5 or more days/week? Yes \_\_\_ No \_\_\_

e. In Section E. (Physical Functioning/Structural Problems), were 3 or more shaded ADLs coded with a 3 (extensive assistance) or 4 (dependent) in self performance? Yes \_\_\_ No \_\_\_

*If the answer to any of these questions is "YES," then the person appears medically eligible for NF level care. Otherwise continue.*

**PROFESSIONAL NURSING SERVICES:**

|  |                      |              |
|--|----------------------|--------------|
| NF.2. a. In Section A, Nursing Services, items 1-8, how many were coded with a 2 or 3 (service needed 3-6 days/week)?  | <b>Enter number.</b> |              |
| b. In Section A, item 11 (Therapies), was the total number of days of therapy 3 or 4 days/week?                        | <b>0-No</b>          | <b>1-Yes</b> |
| c. In Section B, items 1a-1e and 1g-1j (excluding 1f, monthly injections), did you code any of the responses with a 2? | <b>0-No</b>          | <b>1-Yes</b> |
| d. In Section B, items 2a-2d, did you code any of the responses with a 2?  | <b>0-No</b>          | <b>1-Yes</b> |

Compute the nursing services score from 2a-2d and enter it here.

Total

### NF.3. Impaired Cognition

a. Is Section C1a (short term memory) coded with a 1? Yes ☐ No ☐

b. In Section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d or is C2e (None of the Above) checked (Person is able to recall no more than 2 items)? Yes ☐ No ☐

c. Is Section C3 coded with a 2 or 3? Yes ☐ No ☐

d. [Is Section C4A coded with a 1] **OR** [in Section E, is at least one shaded ADL coded with a 2, 3 or 4 in self-performance and a 2 or 3 in support AND C4B (from page 2A Supplemental Screening Tool) is 13 or more]? Yes ☐ No ☐

*If all the answers to the above questions are “yes,” then score this section with a “1.”*

#### NF.4. Behavior Problems

a. In Section D, are one or more of the behaviors from items a-d (wandering, verbally abusive, physically abusive, socially inappropriate behavior) coded with a 2 or 3? Yes ☐ No ☐

b. [Is Section D2A coded with a 1] **OR** [in Section E, is at least one shaded ADL coded with a 2, 3 or 4 in self-performance and a 2 or 3 in support AND D2B (from page 2A Supplemental Screening Tool) is 14 or more]? Yes ☐ No ☐

*If the answer to both questions is yes, then score this section with a "1."*

NF.5. Compute the total nursing score from questions 2, 3 and 4. If the total nursing score is 1 or more, proceed. Otherwise person appears not to be medically eligible for NF level of care. Please proceed to next page.

## Total Nursing

NF.6. In Section E (Physical Functioning/Structural Problems), how many "shaded" ADLs were coded with a 2, 3 or 4 in self-performance AND required a one or more physical assist in support (support coded as 2 or 3)?

### Total ADL Needs

NF.7. Total Nursing and ADL Needs Score (NF.5 + NF.6)

If the Total Nursing and ADL Needs Score is 3 or more, the person appears to be medically eligible for NF level of care. Otherwise, person appears not to be medically eligible. Proceed to next page.

# COMMUNITY OPTIONS CARE PLAN SUMMARY

Agency Name: \_\_\_\_\_ Applicant Name: \_\_\_\_\_

Provider-Assessor #           -     Social Security #    -

Assessment Date:    -

## SECTION 5. SUPPORT SERVICES

|           |   |   |           |  |   |
|-----------|---|---|-----------|--|---|
| <b>1.</b> | <b>EXTENT OF HELP<br/>(HOURS OF CARE ROUNDED)</b>   | For instrumental and personal activities of daily living received over the last 7 days, indicate extent of help from family, friends, and neighbors.<br>a. Sum of time across five weekdays <span style="float: right;">a. <input type="text"/> <input type="text"/> <input type="text"/></span><br>b. Sum of time across two weekend days <span style="float: right;">b. <input type="text"/> <input type="text"/> <input type="text"/></span> | <b>3.</b> | <b>CAREGIVER STATUS<br/>(Check all that apply)</b> | a. Primary caregiver receives help from family or friends in caring for client. <span style="float: right;">a. <input type="text"/></span><br>b. A caregiver is unable to continue in caring activities (e.g., decline in the health of the caregiver makes it difficult to continue) <span style="float: right;">b. <input type="text"/></span><br>c. Primary caregiver is unable to identify other helpers or unable to provide additional care should the need arise (e.g., cannot do more, other caregivers not available, or no funds to hire help) <span style="float: right;">c. <input type="text"/></span><br>d. Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) <span style="float: right;">d. <input type="text"/></span><br>e. Primary caregiver expresses feelings of distress, anger or depression because of caring for client <span style="float: right;">e. <input type="text"/></span><br>f. <span style="float: right;">f. <input type="text"/></span> |
| <b>2.</b> | <b>TWO KEY INFORMAL HELPERS</b><br><br>(Information on two family members, friends, or neighbors most relied on for help with ADLs or IADLs (or could be relied on, if no one now helps with these activities)) | <b>NAME OF PERSON 1 and PERSON 2</b><br>A. (Last/Family Name) (First) _____<br>B. (Last/Family Name) (First) _____<br>a. Lives with client    0 - NO    1 - YES <span style="float: right;">(A) (B)<br/>Pers 1 Pers 2</span><br>2 - No such helper<br>b. Relationship to client<br>0 - Child or child-in-law    2 - Other Relative<br>1 - Spouse    3 - Friend/Neighbor   |           |  |   |

| 4. Person A                    |                          |                          |                                |                                | 5. Person B   |                          |                          |                                |                                |   |
|--------------------------------|--------------------------|--------------------------|--------------------------------|--------------------------------|---|--------------------------|--------------------------|--------------------------------|--------------------------------|---|
| Enter Number of Hours          | A. Current # wkday hours | B. Current # wkend hours | C. Will increase # wkday hours | D. Will increase # wkend hours | E. Extent of knowledge<br>0=full<br>1=partial<br>2=none | A. Current # wkday hours | B. Current # wkend hours | C. Will increase # wkday hours | D. Will increase # wkend hours | E. Extent of knowledge<br>0=full<br>1=partial<br>2=none |
| a. Advice or emotional support |                          |                          |                                |                                |   |                          |                          |                                |                                |   |
| b. ADL care                    |                          |                          |                                |                                |   |                          |                          |                                |                                |   |
| c. IADL care                   |                          |                          |                                |                                |   |                          |                          |                                |                                |   |
| d. Supervision only            |                          |                          |                                |                                |   |                          |                          |                                |                                |   |

Refer to the coding sheet on previous page when filling out this care plan summary.

### 6. MEDICARE/3RD PARTY PAYORS:

| 1<br>Funding Source             | 2<br>Service Category | 3<br>Reason Code/Need Met<br>(List all reasons for service) | 4. DURATION      |                | 5<br>Unit Code | 6<br>Avg # of Units per Month | 7<br>Rate per Unit | 8<br>TOTAL Cost per Month |
|---------------------------------|-----------------------|---|------------------|----------------|----------------|-------------------------------|--------------------|---------------------------|
|                                 |                       |   | 4a<br>Start Date | 4b<br>End Date |                |                               |                    |                           |
|                                 |                       |   |                  |                |                |                               |                    |                           |
|                                 |                       |   |                  |                |                |                               |                    |                           |
|                                 |                       |   |                  |                |                |                               |                    |                           |
|                                 |                       |   |                  |                |                |                               |                    |                           |
|                                 |                       |   |                  |                |                |                               |                    |                           |
|                                 |                       |   |                  |                |                |                               |                    |                           |
|                                 |                       |   |                  |                |                |                               |                    |                           |
| <b>MEDICARE/3RD PARTY TOTAL</b> |                       |   |                  |                |                |                               |                    |                           |

### 7. ALL OTHER SOURCES/SERVICES PROVIDED:

| 1<br>Funding Source                | 2<br>Service Category | 3<br>Reason Code/Need Met<br>(List all reasons for service) | 4. DURATION      |                | 5<br>Unit Code | 6<br>Avg # of Units per Month | 7<br>Rate per Unit | 8<br>TOTAL Cost per Month |
|------------------------------------|-----------------------|---|------------------|----------------|----------------|-------------------------------|--------------------|---------------------------|
|                                    |                       |   | 4a<br>Start Date | 4b<br>End Date |                |                               |                    |                           |
|                                    |                       |   |                  |                |                |                               |                    |                           |
|                                    |                       |   |                  |                |                |                               |                    |                           |
|                                    |                       |   |                  |                |                |                               |                    |                           |
|                                    |                       |   |                  |                |                |                               |                    |                           |
|                                    |                       |   |                  |                |                |                               |                    |                           |
|                                    |                       |   |                  |                |                |                               |                    |                           |
|                                    |                       |   |                  |                |                |                               |                    |                           |
| <b>OTHER FUNDING SOURCES TOTAL</b> |                       |   |                  |                |                |                               |                    |                           |

1. FUNDING SOURCE: Enter the payment code for the funding source which will pay for the recommended service.

2. SERVICE CATEGORY: Enter the appropriate code to indicate the service category recommended to meet the need.

3. REASON CODES: Enter the reason code for recommended service/need being met.

4. DURATION: Enter the Start and End Dates for the proposed service.

5. UNIT CODE: Enter the unit of time which is used in calculating the cost of this service.

6. NUMBER OF UNITS: Enter the number of units needed per month to meet the person's needs.

7. RATE: Enter the current rate for this service based on the maximum allowable MaineCare rate for that specific unit of service in this program as found in the appropriate MaineCare manual.

8. TOTAL COST: Calculate the total cost per month for this service.

Agency Name: \_\_\_\_\_  
 Provider-Assessor # \_\_\_\_\_  
 Assessment Date: \_\_\_\_\_

Applicant Name: \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 MaineCare # \_\_\_\_\_

| SECTION T. ASSESSMENT TYPE/VERSION  |  |  |                                       |
|---|--|--|---------------------------------------|
| 1.  | TYPE                                     | 1. Initial (original) 2. Reassessment  |                                       |
| 2.  | VERSION                                  | 1. Original 3. Conversion 5. Reinstated<br>2. Revision 4. Pending appeal 6. Update   |                                       |
| 3.  | ASSESSMENT/COMMUNITY PROGRAM ELIGIBILITY | 1. <b>Assessment Requested</b> from 6B — <i>Check only one.</i><br>2. <b>Community Program Eligibility</b> from scoring pages — <i>Check all that apply.</i>               |                                       |
| 1. ASMT REQUESTED   | 2. PROGRAM                               | 1. ASMT REQUESTED  | 2. PROGRAM ELIGIBILITY                |
|   | 1. Long Term Care Advisory               |  | 16. 20-day copay to NF MaineCare      |
|   | 2. Adult Day Care Program                |  | 17. 30-day Community MaineCare NF     |
|   | 3. BEAS Home Maker                       |  | 18. Advisory to MaineCare Update      |
|   | 4. MaineCare Day Health                  |  | 19. Adv. Medicare to Private Pay NF   |
|   | 5. Consumer Directed PCA                 |  | 20. Continuing Stay Review            |
|   | 6. Home Based Care                       |  | 21. Extraordinary Circumstances to NF |
|   | 7. Phys. Dis. HCB                        |  | 22. Katie Beckett                     |
|   | 8. Elderly HCB                           |  | 23. Level IV - NF PDN                 |
|   | 9. Adult w/ Disability HCB               |  | 24. Congregate Housing                |
|   | 10. PDN - Level I, II, III               |  | 25. TBI                               |
|   | 11. Adult Family Care Home               |  | 26. MaineCare Home Health             |
|   | 12. Level V - Extended PDN               |  | 27. PDN Medication - Level VI         |
|   | 13. NF Assessment                        |  | 28. PDN Venipuncture Only - Level VII |
|   | 14. 20-day Medicare/MaineCare            |  | 29. Cons. Directed HCB                |
|   | 15. Medicare to MaineCare                |  |                                       |
| 4.  | CONSUMER CHOICE (Choose one.)            | 1. Community Options 3. Advisory only 5. NF<br>2. Residential Care 4. No choice  |                                       |
| 5.  | ADVISORY PLAN                            | Program referrals given to consumer as an advisory 0 - No 1 - Yes<br>Advisory medical eligibility determination is valid for 30 days.<br>Valid from: _____ to _____ 0 - NA |                                       |
| SECTION U. NF MEDICAL ELIGIBILITY   |  |  |                                       |
| 1. Based on this assessment, the consumer appears to be medically eligible for NF level of care. 0 - No 1 - Yes |  |  |                                       |

| SECTION V. AWAITING PLACEMENT                   |                                  |                                   |                                |
|---|----------------------------------|-----------------------------------|--------------------------------|
| 1. a. FOR:                                      | 0. NA                            | 1. NF                             | 2. MaineCare HCB - Elderly, AD |
| b. AT:  | 0. NA                            | 3. Home                           |                                |
|   | 1. NF                            | 4. Out-of-state                   |                                |
|   | 2. Hospital (specify) _____      |                                   |                                |
| c. Valid eligibility: from _____ to _____       | 0 - NA                           |                                   |                                |
| SECTION W. NF/HOSP/HHA DATES                    |                                  |                                   |                                |
| 1. Acute care denial date:                      | 0 - NA                           |                                   |                                |
| 2. First Non-SNF Date:                          | 0 - NA                           |                                   |                                |
| 3. Last day private pay:                        | 0 - NA                           |                                   |                                |
| 4. Late notification date                       | 0 - No                           | 1 - Yes                           |                                |
| 5. Bed hold expired                             | 0 - No                           | 1 - Yes                           |                                |
| 6. Home Health end date:                        | 0 - NA                           |                                   |                                |
| SECTION X. NF FACILITY                          |                                  |                                   |                                |
| 1. a. Will be entering a NF                     | 0 - No                           | 1 - Yes                           |                                |
| b. Is currently in a NF                         | 0 - No                           | 1 - Yes                           |                                |
| c. NF Name:                                     | 0 - NA                           |                                   |                                |
| d. Eligibility start date:                      | 0 - NA                           |                                   |                                |
| e. Reassess date:                               | 0 - NA                           |                                   |                                |
| f. End date: (30-day MaineCare only)            | 0 - NA                           |                                   |                                |
| g. Admission date:                              | 0 - NA                           |                                   |                                |
| SECTION Y. LATE SUBMISSION                      |                                  |                                   |                                |
| 1a. Reason:                                     | 1b. To:                          |                                   | 0 - NA                         |
| <input type="checkbox"/> a. Provider not chosen | <input type="checkbox"/> a. BMS  | <input type="checkbox"/> c. BEAS  |                                |
| <input type="checkbox"/> b. Financial pending   | <input type="checkbox"/> b. HCCA | <input type="checkbox"/> d. Other |                                |
| <input type="checkbox"/> c. Consumer request    |                                  |                                   |                                |

| SECTION Z. COMMUNITY BENEFITS  |          |                        |                          |                          |  |
|--|----------|------------------------|--------------------------|--------------------------|--|
| FUNDING SOURCE (from Care Plan)  | PROVIDER | ELIGIBILITY START DATE | REASSESS DATE            | WAIT LIST                |  |
|  |          |                        |                          | <input type="checkbox"/> |  |
|  |          |                        |                          | <input type="checkbox"/> |  |
|  |          |                        |                          | <input type="checkbox"/> |  |
| RESIDENTIAL CARE REFERRAL  |          |                        |                          |                          |  |
|  |          |                        |                          | <input type="checkbox"/> |  |
| BENEFITS DENIED  |          |                        |                          |                          | NOTICE DATES   |
| FUNDING SOURCE   | ACTION   | REASON                 | 10-DAY                   | DISCHARGE DATE           | DISCHARGE TO   |
|  |          |                        | <input type="checkbox"/> |                          |  |
|  |          |                        | <input type="checkbox"/> |                          |  |
|  |          |                        | <input type="checkbox"/> |                          |  |
| SIGNATURE  |          |                        |                          |                          | Date of denial: _____<br><input type="checkbox"/> 10-day Date: _____<br><input type="checkbox"/> 60-day Notice: _____<br><input type="checkbox"/> Appeal<br>Reinstated 0 - No 1 - Yes<br>Date: _____ |
| Assessment Date _____ Assessment Version _____ Assessor Signature _____ Signature Date _____ |          |                        |                          |                          |  |
| FOR OFFICE USE ONLY BEAS/BFI   |          |                        |                          |                          |  |
| <input type="checkbox"/> APRC  |          |                        |                          |                          |  |
| BEAS request date _____ to _____   |          |                        |                          |                          |  |
| BFI approved begin date _____ to _____   |          |                        |                          |                          |  |